Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: PARK PLAZA HOSPITAL 3255 W PIONEER PKWY ARLINGTON TX 76013-4620	MFDR Tracking #:	M4-08-4597-01
Respondent Name and Box #: Valley Forge Insurance Co. Box #: 47		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $1,588.13
3. Hospital Bill
4. EOB
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Carrier contends that payment of the recommended allowance equals payment of the outpatient facility charges at a fair and reasonable amount pursuant to the criteria set forth in Texas Labor Code section 413.011(b) of the Texas Workers Compensation Act. Carrier's explanation of review advises that the Carrier was making payment based on a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in Texas labor Code 413.011. In light of the reduced expenses incurred in an outpatient setting, it is unreasonable to pay more for an outpatient procedure or surgery than an inpatient surgery. The established per diem rate for an inpatient surgical day is set at $1,118.00. The per diem rate for a non-surgical inpatient medical stay is set at $870.00. Using these two rates as anchor points, reimbursement is determined based on the amount of time spent in the operating room."…

"The total recommended allowance represents a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in section 413.011 of the Texas Workers' Compensation Act. The Carrier's allowance achieves effective medical cost control, takes into account payments made to others with equivalent standard of living, and considers the increased security of payment."

"Carrier also asserts that this Medical Fee Dispute is not properly before the TDI-DWC. Valley Forge Insurance Company received the Request for Reconsideration after the MDR was filed with TDI."… "It is only after being dissatisfied with the Carrier 'final action' in response to the Request for Reconsideration that a Provider may request MDR per rule 133.250(h). The Requestor did not allow the Carrier to provide its response or take 'final action' before it filed this MDR."

Principle Documentation:

1. Response Package
2. EOBs

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
3/29/2007	150, W1, W4, 647-002, 850-243, 900-030, 920-002	Outpatient Surgery	$1,588.13	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 150 – "Payment adjusted because the payer deems the information submitted does not support this level of service."
   - W1 – "Workers compensation state fee schedule adjustment"
   - W4 – "No additional reimbursement allowed after review of appeal/reconsideration."

   With additional payment advice codes:
   - 647-002 – "Reimbursement has been calculated based on a percentage of the charges."
   - 850-243 – "ABR: The recommended payments above reflect a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set froth in section 413.011(d) of the Texas Workers' Compensation Act. M – No MAR $0.00" and "M – No MAR $1,000.00"
   - 900-030 – "ABR: This bill was reviewed through the advanced bill review program"
   - 920-002 – "In response to provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance."
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.250(h), effective May 2, 2006, 31 TexReg 3544, states that "if the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution – General)." Review of the documentation submitted by the requestor finds that the requestor has not provided convincing evidence that insurance carrier had taken "final action on the medical bill after reconsideration" prior to the requestor filing for medical fee dispute resolution. Per 28 TAC §133.250(f) "The insurance carrier shall take final action on a reconsideration request within 21 days of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits for all items included in a reconsideration request in the form and format prescribed by the Division." Review of the documentation submitted by the requestor finds that the requestor did not provide a copy of an EOB for the reconsideration as required under 28 TAC §133.307(c)(2)(B). Review of the requestor's position statement finds a handwritten notation by the requestor that "Carrier has just on 3/13/07 put bill to be reviewed, we are filing this MDR to protect our rights, as they most likely wont have appeal done!" [sic] Review of the request for reconsideration finds that the request for reconsideration is dated February 28, 2008. This request for Medical Fee Dispute Resolution was received by the Division on March 13, 2008, only 14 days after the date of the request for reconsideration. The requestor did not wait the 21 days to receive the notice of final action from the insurance carrier, and the requestor asserts on its position statement that it had not received notice of final action prior to filing the request for medical fee dispute resolution. The Division concludes that the requestor has not satisfied the requirements of 28 TAC §133.250(h).
5. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues"… This request for medical fee dispute resolution was received by the Division on March 13, 2008. Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).

6. Division Rule at 28 TAC §133.307(c)(2)(G) , effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable"... This request for medical fee dispute resolution was received by the Division on March 13, 2008. The requestor's position statement asserts that "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of $992.50 for APC # 0053. Allowing this at 140% would yield a fair and reasonable allowance of $2084.25, for both procedures. Also, Medicare would have allowed $826.68 for APC # 0686. Allowing this per the multiply procedures rules, they would have allowed $603.88. Based on their payment of $1,100.00 a supplemental payment is still due, based on the APC rate." However the requestor did not discuss or explain how it determined that 140% of the Medicare rate would yield a fair and reasonable reimbursement. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. Nor has the requestor discussed how the proposed methodology would be consistent with the criteria of Labor Code §413.011, or would ensure similar reimbursement to similar procedures provided in similar circumstances. Additionally, the requestor did not provide documentation, such as Medicare fee schedules, redacted EOBs, payment policy manual excerpts, or other evidence, to support the Medicare payment calculation. Review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with 28 TAC §134.1. The request for additional reimbursement is not supported.
7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor is not eligible to request medical fee dispute resolution according to 28 Texas Administrative Code §133.250(h). Additionally the Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(F)(iii) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.250, §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.